Comprehensive Health Profile

Date: ____________________
Last Name: ______________________ First Name: ___________________________ Date of Birth: ______________
Address: ______________________________ City: ____________________ State: _______ Zip: ______________
Home Phone: ____________________ Work Phone: ____________________ Cell Phone: ____________________
Email: _______________________________ SSN: ____________________ Occupation: ____________________
Marital Status: S M D W Partner's Name: _____________________________ Do you have children? **Y N**
Who referred you or how did you hear about our office? ____
Do you have insurance you want us to bill for your care? ____

What are your reasons for seeking care at our office? Please rank the following
(4=Very Important to me; 3=Important to me; 2=Not so Important to me; 1=Does not apply)

___Improvement of my physical symptoms
___Improvement of my emotional/mental symptoms
___Improvement in my ability to respond to stress
___Improvement in my enjoyment/quality of life

Your Symptoms and How They May Influence Your Life:

Do you have a current health/life concern or symptom? If no, please describe the reason you are consulting our office then skip to History of Physical Stress Section. If yes, please describe: ______________________________
____
When did it begin? _______________ What were the circumstances? _______________________________
Is the reason you are consulting our office the result of an injury at work or an auto accident? **Y N** If so, date of injury? ____
Have you done anything about this concern, or been given any advice or treatment for it? **Y N** If yes, what were you told and by whom?____
____
What was done? ____
Did it seem to work? **Y N** What was different about your symptom or concern after treatment? _______________
____

Please grade the level to which the concern/symptom affects the following aspects of your functioning/quality of life **(0=does not seem to affect me; 1=slightly affects me; 2=moderately; 3=extremely)**

Work	0 1 2 3	Recreation/Play	0 1 2 3	Rest/Sleep	0 1 2 3
Social Life	0 1 2 3	Walking	0 1 2 3	Sitting	0 1 2 3
Exercise	0 1 2 3	Eating	0 1 2 3	Love Life	0 1 2 3

Comments: ____
Have any other family members had the same or similar concerns? **Y N**
What did he/she do about it? ____
Did it seem to work? **Y N** How aware are you of your symptom/concern during the day? 0 1 2 3 at night? 0 1 2 3
Is there any activity during which you totally, or almost totally, forget about this condition, symptom, or concern? ___
____
____
Why do you think this is happening, or continues to happen to you? _______________________________
____
Do you think this is the sole cause? **Y N** If no, what else is involved? ___________________________
____
Are you doing anything differently in your life because of this symptom/condition/concern? **Y N** If yes, what?______
____
If it were to go away tomorrow, what would be different about your life? ___________________________
____
Since the development of this symptom/concern, have you:
Changed any habits? **Y N** If so, what? ____
Held or touched a part of your body more often or differently? **Y N**
Moaned, cried, or made sounds that you usually do not make? **Y N**
Which best describes your current feeling about yourself and your situation?
___I feel helpless, like little or nothing is working.
___This is terrible, really bad; I hope you can fix it for me.
___I feel stuck.
___I deserve more than this, and would like you to assist me with my healing.
___Other, please describe: ____

HISTORY OF PHYSICAL STRESS

Birth Stress: Were there any problems associated with your mother's pregnancy with you? (check all that apply)
☐Falls/Injury ☐Illness ☐Difficult ☐Don't know
Comments: ____________________

Was your birth: (check all that apply) ☐Traumatic ☐"C" section ☐Breech ☐Forceps or Suction ☐Cord around neck ☐Prolonged ☐Very Fast ☐Natural ☐Drug induced ☐Home ☐Hospital ☐Birthing Center
Comments: ____________________

General Physical Trauma: Falls: (check all that apply, give age & year) ☐Crib/Carriage ________ ☐Steps ________ ☐On ice ________ ☐Out of Tree ________ ☐Bars at school ________ ☐Skiing/Snowboarding ________ ☐Other falls (please describe): ____________________
☐Knocked unconscious ________ ☐Used crutches/cane ________ ☐Broken Bones/Sprains (please describe)____________________
☐Involved in combat ________ ☐Physical fight ________ ☐Physical abuse ________ ☐Sports Injuries________
☐Extensive dental work/orthodontia ________ ☐Other, please describe: ____________________

Accidents, near accidents, driver or passenger: (check all that apply, give age & year)
☐Automobile, details: ____________________
☐Motorcycle ________ ☐Bus ________ ☐Train ________ ☐Bicycle ________ ☐Plane ________ ☐Other: ____________Comments: ____________________

Daily Activities: (check all that apply)
☐Sit ☐Stand ☐Walk ☐Desk work ☐Phone work ☐Sports ☐Exercise ☐Computer work
☐Watch TV ☐Driving/commuting ☐Play musical instrument ☐Read for prolonged periods
☐Mechanical work ☐Heavy lifting ☐Wear contacts ☐Wear glasses ☐Wear bifocals
☐Comments: ____________________

Medical Intervention: (check all that apply, give age & year)
☐Hospitalization *why?* ____________________
☐Surgery *why?* ____________________
☐Chemotherapy ______________ ☐Radiation ______________ ☐Casts/Collars ______________
☐Spinal/neck brace ______________ ☐Corrective shoes. bars, lifts ______________ ☐Physical Therapy ______________ ☐Spinal tap/injections ______________ ☐X-rays ______________
☐Transfusion ______________ ☐Organ Removal ______________ Comments: ______________

Have you or a family member suffered a serious illness? ____________________
Do you have a family doctor? **Y N** Who? ____________________
Date of last medical consultation & result: ____________________
For women: Are you pregnant? **Y N** Date of last monthly period: ____________________
How do you grade your overall physical health? ☐Excellent ☐Good ☐Fair ☐Poor ☐Getting Better ☐Getting Worse

HISTORY OF CHEMICAL STRESS

Birth Stress: During your mother's pregnancy, did she: (check all that apply)
☐Use prescription drugs ☐Use nonprescription drugs ☐Smoke ☐Consume alcohol/drugs ☐Don't know
At birth was your mother: (check all that apply) ☐Conscious ☐Semi-conscious ☐Unconscious ☐Given spinal anesthesia ☐Given chemicals to alter or induce labor ☐Don't know

General Chemical Stress: Do you or have you ever taken: (check all that apply) ☐Prescription drugs ☐Over-the–counter drugs ☐Antibiotics ☐Other drugs ☐Tobacco
List all current and past Medications: (include reason and length of time you were on them) ____________________

Do you or have you worked with or ever been exposed to: ☐Chemicals ☐Fumes ☐Dust ☐Powders/Particles ☐Smoke ☐ Other substances________________

Do you consume: ☐Alcohol ☐Coffee/caffeine ☐Processed food ☐Artificial sweeteners ☐Refined sugar ☐Sodas ☐Tap water Describe diet: ________________

HISTORY OF EMOTIONAL STRESS

Were you incubated or isolated after birth? **Y N** Were you: ☐Bottle fed ☐Nursed ☐ Both

PAST General Emotional Trauma: (check all that apply and note severity: mild, moderate, extreme)

☐Childhood ________ ☐Personal relationship ________ ☐Change of job/career ________

☐School ________ ☐Divorce/separation ________ ☐Change of lifestyle ________

☐Recreational ________ ☐Work related ________ ☐Loss of loved one ________

☐Parent's divorce ________ ☐Commuting ________ ☐Abuse ________

☐Family ________ ☐Financial ________ ☐Stress of being sick/ill ________

Comments: ________________

LIFESTYLE PROFILE

How do you grade your emotional/mental health? ☐Excellent ☐Good ☐Fair ☐Poor ☐Getting Better ☐Getting Worse

How do you grade your overall quality of life? ☐Excellent ☐Good ☐Fair ☐Poor ☐Getting Better ☐Getting Worse

Have you pursued other avenues of growth, healing or personal development? (check all that apply and note who you saw, for how long and if you are still going)

☐Chiropractic ________ ☐Acupuncture ________

☐Massage/Bodywork ________ ☐Homeopathy ________

☐Psychotherapy ________ ☐Ayurvedic Medicine ________

☐Osteopathy ________ ☐Physical Therapy ________

☐Aromatherapy ________ ☐Energy Work ________

☐Rebirthing ________ ☐Sound/Light Therapy ________

What aspects of your life please you, bring you joy, and help you to feel better about yourself? ________________

What particular factors or elements about your life experiences, family, work, recreation, past injuries, genetics, dietary programs, exercises, outlook, etc.:

Do you feel impair your opportunity for full glowing health? ________________

Do you feel give you an edge or add to your life and health? ________________

Which of the following do you practice regularly (check all that apply and how many times per week)

☐Exercise ________ ☐Yoga ________ ☐Chi Gong/Tai Chi ________ ☐Movement/Dance ________

☐Meditation ________ ☐Prayer ________

List any herbs, nutritional supplements or natural remedies you regularly take: ________________

When stressed how do you "center yourself" or "re-group"? ________________

Is there anything else you wish to share which may help us better understand you and why you have chosen to come to this office? ________________

What type of results would motivate you to tell others about the care you receive in this office, and encourage others to get under care? ________________

When communicating with you about your spine, nervous system, health and wellness (circle your preference):

a) Visual Communication- Mostly show me pictures and diagrams.
b) Verbal Communication- Mostly talk to me about the changes I'm making.
c) Kinesthetic Communication- Mostly I need to feel it.

LIFE INTENTION

We are committed to helping you reach and exceed your health and life goals. We know that a true state of Well-Being, one in which you feel alive, vibrant, and fulfilled in all the major areas of your life, is possible for you. If you were living your "Ultimate" life, what would it be like, look like, feel like- Physically, Emotionally, Mentally, Financially, Relationally and Spiritually? ____

Wellness & Quality of Life Survey

Name: ______________________________ **Date**: _________________________

Please circle the number that best describes your current experience.

I. Physical State

How often do you experience the following symptoms?

	Never	Rarely	Occasionally	Regularly	Constantly
1. Physical Pain (neck/back ache, sore arms/legs, etc.).	1	2	3	4	5
2. Feeling of tension, stiffness or lack of flexibility.	1	2	3	4	5
3. Fatigue or low energy.	1	2	3	4	5
4. Colds and flu.	1	2	3	4	5
5. Headaches (of any kind).	1	2	3	4	5
6. Heartburn or indigestion.	1	2	3	4	5
7. Nausea or constipation.	1	2	3	4	5
8. Menstrual discomfort.	1	2	3	4	5
8. Allergies or skin rashes.	1	2	3	4	5
9. Dizziness or light-headedness.	1	2	3	4	5
10. Accidents or near accidents or falling or tripping.	1	2	3	4	5
11. Ease of recovery from injury.	1	2	3	4	5
12. Restricted or shallow breathing.	1	2	3	4	5

II. Mental/Emotional State

Rate the following questions with respect to frequency:

	Never	Rarely	Occasionally	Regularly	Constantly
1. If pain is present, how distressed are you about it?	1	2	3	4	5
2. Presence of negative or critical feelings about yourself.	1	2	3	4	5
3. Experience of moodiness, temper or anger outbursts.	1	2	3	4	5
4. Experience of depression or lack of interest.	1	2	3	4	5
5. Over reacting to life's stresses.	1	2	3	4	5
6. Being overly worried about small things.	1	2	3	4	5
7. Experience of vague fears or anxiety.	1	2	3	4	5
8. Difficulty thinking or concentrating or indecisiveness.	1	2	3	4	5
9. Difficulty falling or staying asleep.	1	2	3	4	5
10. Experience of recurring thoughts or dreams.	1	2	3	4	5

III. Stress Evaluation

Evaluate your stress relative to the following:

	None	Slight	Moderate	Considerable	Extensive
1. Family.	1	2	3	4	5
2. Significant Other.	1	2	3	4	5
3. Physical Health.	1	2	3	4	5
4. Finances.	1	2	3	4	5
5. Sex Life.	1	2	3	4	5
6. Work or School.	1	2	3	4	5
7. Coping with daily problems.	1	2	3	4	5

IV. Life Enjoyment

Rate the following statements with respect to frequency:

	Never	Rarely	Occasionally	Regularly	Constantly
1. Openness to guidance from your “inner voice/feelings”.	1	2	3	4	5
2. Experience of peace, relaxation, ease or well-being.	1	2	3	4	5
3. Presence of positive feelings about yourself.	1	2	3	4	5
4. Interest in maintaining a healthy lifestyle (e.g., diet, fitness, etc.).	1	2	3	4	5
5. Feeling of being open, aware and connected when relating to others	1	2	3	4	5
6. Level of confidence in your ability to deal with adversity.	1	2	3	4	5
7. Level of compassion for and acceptance of others.	1	2	3	4	5
8. Experience feelings of joy or happiness.	1	2	3	4	5
9. Experiencing gratitude.	1	2	3	4	5
10. Level of satisfaction with your sex life.	1	2	3	4	5
11. Satisfaction with the level of recreation in your life.	1	2	3	4	5
12. Time devoted to things you enjoy.	1	2	3	4	5

V. Overall Quality of Life

Evaluate your feelings relative to your quality of life:

	Unhappy	Mostly Dissatisfied	Mixed	Mostly Satisfied	Delighted
1. Your personal life.	1	2	3	4	5
2. Your wife/husband or “significant other”.	1	2	3	4	5
3. Your romantic life.	1	2	3	4	5
4. Your job.	1	2	3	4	5
5. Your co-workers.	1	2	3	4	5
6. The actual work you do.	1	2	3	4	5
7. The handling of problems in your life.	1	2	3	4	5
8. What you are actually accomplishing in your life.	1	2	3	4	5
9. Your physical appearance - the way you look.	1	2	3	4	5
10. Your ability to adapt to change in your life.	1	2	3	4	5
11. Overall contentment with your life.	1	2	3	4	5

NETWORK SPINAL ANALYSIS (NSA) and SOMATORESPIRATORY INTEGRATION (SRI)

Consent Form

I hereby request and consent to receiving spinal care, including wellness education in this office by chiropractors who provide ***Network Spinal Analysis (NSA) Care and Somato Respiratory Integration (SRI).*** NSA a low force approach which has unique outcomes and clinical results. These practitioners choose to practice NSA, as he/she is professionally and personally confident in regard to the safety and effectiveness of this form of care.

This office provides care in accordance with the *Council on Chiropractic Practice Guidelines* and my doctors have been trained in traditional chiropractic care and certified in the highest level of Network Spinal Analysis Care.

NSA consists of gentle touch contacts along the neck and back to achieve greater communication between the brain and body, and new sensory and motor strategies. NSA adopts an approach associated with somatic (body/spinal awareness) training. NSA does not attempt to manually, or by instrument, manipulate spinal fixations structurally (often associated with a snapping or popping sound), nor does it directly treat painful areas of the spine and body. ***Instead, by enhancing my body's awareness of itself and specifically my spine, I understand I can develop new strategies for healing, adapting to stress, and experiencing wellness. These strategies promote spontaneous self-correction and self-regulation of spinal tension patterns and healing.*** There is a body of research characterizing NSA care and documenting its unique and significant wellness benefits.

NSA care received in this office involves the development of new and unique spontaneous spinal wave motions, other body movements, and oscillations. These waves, which are suggested to be associated with the greater spinal stability, the re-distribution of energy, and the transfer of internal information are also associated with greater wellness, improved quality of life, and increased life enjoyment.

SRI and Wellness Education is specifically designed to educate you to your body rhythms and inner wisdom through focused attention, gentle breath, movement, and touch. With SRI you will experience having heightened awareness as the "higher" brain, (the part responsible for consciousness and awareness), focuses its attention on a region and/or sensation that was formerly repressed, discarded, denied or desensitized. This allows for greater connections between your higher brain and your body, fostering the ability to develop internally customized choices for your body and for your life.

I also understand that, in addition to NSA and SRI Care and wellness education, my practitioners may perform additional examinations or assessments and offer health/spinal care or advice that is consistent with my individual needs.

Please Read and Sign the Following:

It has been explained to my satisfaction, and I understand that the care offered at this office is not a form of, or replacement for, the diagnosis or treatment of any symptom, disease, or malady. Instead, it is a form of wellness care and self-education that empowers my connection with my body-mind and develops new strategies for spinal and nervous system integrity and wellness. It

develops new capacities in my body for the identification of, spontaneous release of, and redirection of tension, including those that are unique to NSA care.

I understand that I may experience physical sensations such as energy, vibration, heat, or at times discomfort or total relaxation and ease. Sensations may be subtle, or at times very intense, as one experiences greater depth in his/her range of healing stages.

I understand it is common to experience a wider range of motion and emotion during care. It is common, as care progresses, to find new options in the body and in life, which often lead to significant life changes. ***This form of care is NOT suggested for those individuals who wish to remove a symptom or condition without the occurrence of other fundamental changes in their lives. The care in this office often promotes significant changes in health choices, lifestyle, experience of the body-mind, emotion, and consciousness.***

Rather than simply attempting to return me to my previous state minus a symptom, these chiropractors instead choose to help me achieve new levels of wellness and life potential that I may never have had before.

Although in this office we seek to help develop new strategies for wellness and spinal and nerve system integrity, as a chiropractor the sole condition of concern is that of the vertebral subluxation. Our insurance carrier requires that the following information be given to you and signed by you prior to commencing care.

In Network Care, we categorize these subluxations into two categories, a structural segmental distortion and a spinal cord/nerve elongation or stretching. Through the gentle force applications at the spine to enhance spinal and nerve system integrity subluxations are corrected. The only condition we offer to diagnose and correct is the vertebral subluxation and loss of spinal and neural integrity in relationship to this. We do not offer to treat any other condition, disease or symptom. If during the course of our spinal assessment/examination we encounter non-chiropractic or unusual findings, we will advise you of this. If you desire advice on further diagnosis or treatment of this condition, situation or circumstance, we will recommend that you seek the services of another health care provider whose practice is geared towards such differential diagnosis and treatment.

I have read, or have had read to me, this CONSENT TO RECEIVE NETWORK SPINAL ANALYSIS (NSA) CARE and ***understand that the care in this office is different from what many consumers may expect from chiropractors practicing manipulative therapy. I agree to receive care, which consists of or includes NSA care and wellness education. I understand that I am not passive in this process, but that I am an active participant in my care and in my healing.***

____
PRINTED NAME OF PRACTICE MEMBER

____________________________________ ________________________
SIGNATURE OF PRACTICE MEMBER DATE

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW CHIROPRACTIC AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Amaral Chiropractic (the "Practice") is committed to maintaining the privacy of your protected health information ("PHI"), which includes information about your health condition and history as well as the care and treatment you receive from the Practice and other health care providers. This notice details how your PHI may be used and disclosed to third parties for purposes of your care, payment of your care, health care operation of the practice and for other purposes permitted or required by law. This notice also details your rights regarding your PHI.

This Practice employs multiple doctors of Chiropractic and practitioners at any given time. However for purposes of compliance with the Health Information Portability and Accountability Act (HIPAA) Privacy rules, all doctors are deemed to be a part of a single Organized Health Care Arrangement, which means that they operate as an integrated unit; that they will share protected health information in order to carry out chiropractic care (including coverage for each other), payment for services rendered and health care operations; that this notice provided serves as a joint notice made by each doctor, practitioner and staff person and that each of them will abide by the terms of this notice.

We provide most on-going care in an "open entrainment" area. It is NOT the environment used for taking patient histories, performing examinations or presenting reports of findings. These procedures are completed in a private, confidential setting. This means that statements made by you or employees of the Practice during treatment may be overheard by others. There are various interpretations under federal law with respect to what is known as "incidental disclosures" of health information. It is our view that the kinds of matters related in an "open entrainment" environment are incidental matters. If you have comments or information you wish to share privately when you come into the entrainment room please inform the doctor or staff and we will accommodate your needs. You can also communicate private information with us via email at john@wellbeingcenter.com, christina@wellbeingcenter.com or omri@wellbeingcenter.com

In the course of your care at Amaral Chiropractic, we may use or disclose personal and health related information about you in the following ways:

*Your PHI, including your clinical records may be disclosed to another health care provider or hospital if it is necessary to refer you for further diagnosis, assessment or treatment.
*Your health care records as well as your billing records may be disclosed to another party, such as an insurance carrier, or your employer if they are responsible for the payment of your services.
*Your name, address, phone number and health care records may be used to correspond with you during or after your care. This may include contacting you regarding: appointment reminders, recommendation notices, birthdays, holiday, referral thank-you's, practice events, or other health related information (ie. Newsletters, e-mails, etc.) that may be of interest to you, as well as other similar correspondence.

Further you have the right to inspect or obtain a copy of the information we will use for these purposes. If you are not at home to receive an appointment reminder call, a message may be left on your answering machine. You also have the right to refuse to provide authorization for this office to contact you regarding these matters. **This request must be made in writing.** If you do not provide us with this authorization it will not affect the care provided to you or the reimbursement avenues associated with your care.

Under federal law, we are also permitted or required to use or disclose your health information without your consent or authorization in the following circumstances:
*If we are providing health care services to you based on the orders of another health care provider.
*If we provide health care to you in an emergency or if we are required by law to provide care and are unable to obtain your consent after attempting to do so.
*If we are ordered by courts or another appropriate agency. Also, when required by law (ie. case of child abuse and neglect) or for special government functions (ie. military, veteran) and correctional institutions in the case of inmates.
*If you are involved in a Workers' Compensation claim, we may be required to disclose your PHI to an individual or entity that is part of the Workers' Compensation system.
*If we contract with a business associate to provide a service necessary for your treatment, payment for your services, and health care operations (ie. practice or front desk coverage, billing or transcription service, etc.).

Any use or disclosure of your PHI, other than as outlined above, will only be made upon your written authorization. We normally provide information about your health care to you in person at the time you receive chiropractic care from us. We may also email or mail information to you regarding your health care or about the status of your account. If you would like to receive this information at an address other than your home please advise us in writing.

You have the right to inspect or request a copy of your PHI for five years from the date the record was created or as long as the information remains in our files. In addition you have the right to request an amendment to your health information. The Practice has 30 days to comply. Requests to inspect, copy, or amend your health related information must be made in writing.

We are required by law to maintain the privacy of your patient file and the PHI therein. We are also required to provide you with this notice of our privacy practices with respect to your PHI and to abide by the terms of this notice while it is in effect. We reserve the right to alter or amend the terms of this privacy notice. If changes are made we will notify you in writing as soon as possible following the changes.

If you have a complaint regarding our privacy notice, our privacy practices or any aspect of our privacy activities please let our staff know.

Your signature indicates your authorization of the policies outline in this notice.

Name printed	**Signature**	**Date**

Dr. Omri Sitton - Statement of Purpose – Well Being Center

The purpose in sharing my philosophy and clinical objectives is to clearly define my approach to chiropractic, the healing arts and those I serve in this office. I wish to clearly communicate my responsibilities in this exciting relationship.

The following concepts are central to the way in which I practice the ChiroSomatics Approach. I am pleased to share these ideas with you so our purpose can be in alignment from the very beginning.

There is intelligence within each individual, which keeps that person alive, but also coordinates, repairs, renews and heals every cell of the body.

The nervous system is the main distribution center and coordinating system for this innate intelligence and can be accessed through light touch throughout your bodymind.

Proper coordination, repair, movement, healing and genetic potential cannot be fully expressed when this life power and intelligence is blocked or redirected.

The purpose of the ChiroSomatics session is to correct subluxations (constricted regions in the bodymind) thus allowing a greater communication of this life power and coordinating intelligence to promote better health through optimized function and improved structure.

Everyone, in spite of specific symptoms or ailments, can benefit from a more flexible and subluxation-free bodymind.

Symptoms are not necessarily a sign of illness, they can occur to alert the individual of the need for change.

Specific location of symptoms does not correlate to specific subluxations needing to be adjusted. Severity of symptoms does not correlate to severity of subluxations. The reduction of symptoms is not an effective indicator of improved health.

An individual may have symptoms and not need a session on a particular visit. An individual may have no symptoms and may require extensive care on a particular visit. A person's symptoms are not necessarily in direct relationship to his or her prognosis.

I do not treat specific symptoms, conditions or ailments, other than subluxations. I do not imply that any particular adjustment or series of adjustments will have a direct effect on any symptom or condition a person may be presenting.

Research studies show thousands of patients receiving chiropractic adjustments report improved physical and emotional health and well-being.

I encourage any individual having concerns about symptoms or ailments to consult with a disease or symptom care specialist.

By their very intent, various treatments may interfere with the functioning of the nervous system. This may include drugs such as pain relievers, muscle relaxers, anti-inflammatory compounds and mood-altering medication. This can often prolong the time required for spinal correction.

Medication levels for an inflexible body-mind stuck in sickness are not necessarily the same as for a body becoming well.

I will not venture into the practice of medicine by advising about the need for reduction of medications. I suggest you speak with your physician to determine the objectives and goal to be obtained by receiving a particular medical treatment and determine if this is consistent with your desire for wellness at this point in time.

Your physician may guide you in changing any medication or treatments you are presently utilizing to accommodate for your changing body-mind.

Consistent with the above concepts, I locate and adjust vertebral subluxations using the techniques I believe to be the most honoring and effective.

Sincerely,

Dr. Omri Sitton, D.C., B.S., B. S.